TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Jaime Miles, D.C.

Respondent Name
Texas Mutual Insurance Company

MFDR Tracking Number
M4-17-1750-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
February 7, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "DESIGNATED DOCTOR EXAMINATION NO PAYMENT RECEIVED"

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Although the requestor's bill lists date 9/9/16 the DWC69 form lists exam date 9/24/16 and the narrative report identifies the exam date as 9/24/16 … Texas Mutual declined to issue payment absent substantiation of the billing by the documentation."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 9, 2016	Designated Doctor Examination	$650.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.250 sets out the fee guidelines for maximum medical improvement and impairment rating provided on or after September 1, 2016.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - Comment: "DATE OF EXAM ON REPORT AND DWC 69 REFLECT DATE OF SERVICE AS 9/24/16. PLEASE VERIFY DATE OF SERVICE BILLED."
   - CAC-P12 – Workers' compensation jurisdictional fee schedule adjustment.

- CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724 – No additional payment after a reconsideration of services.
- 892 – Denied in accordance with DWC rules and/or medical fee guideline, including current CPT code descriptions/instructions.

Issues

Are Texas Mutual Insurance Company's reasons for denial of payment supported?

Findings

Jaime Miles, D.C. is seeking reimbursement for a designated doctor examination performed on September 9, 2016. Texas Mutual Insurance Company (Texas Mutual) denied the service with claim adjustment reason code 892 – "DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE, INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS," and additional comments, "DATE OF EXAM ON REPORT AND DWC 69 REFLECT DATE OF SERVICE AS 9/24/16. PLEASE VERIFY DATE OF SERVICE BILLED."

28 Texas Administrative Code §134.250(1) requires the submission of reports and narratives to support the billed service. Review of the submitted information finds a Report of Medical Examination (DWC069) and narrative report for an examination performed on September 24, 2016. The division finds the documentation does not support the billed service. Texas Mutual's denial reason is supported. Reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Laurie Garnes	March 3, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.